NOTICE: THIS FORM MUST BE PRINTED ON 14 INCH PAPER

PART-TIME EMPLOYEES GROUP — NEW JERSEY STATE HEALTH BENEFITS PROGRAM APPLICATION

HA-0684-1005p

Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

DIVISION USE ONLY

Effective Dates:

Event Reason:

1. EMPLOYEE INFORMATION — This section must be filled out *completely*. Please print or type.

Social Security Number

Last Name

Title (Jr.,Sr., etc.)

First Name

MI

Street Address (Include Apartment #)

City

State

Zip Code + 4

Date of Birth (mm/dd/yy)

Gender (M/F)

Status: ☐ - Single ☐ - Married ☐ - Domestic Partnership ☐ - Divorced ☐ - Widowed

(Area Code) Home Telephone Number

Are you transferring your health benefits from another SHBP participating employer?

No ☐ Yes ☐ If yes, name of employer _____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION

☐ I wish to be covered under NJ PLUS **and** the Employee Prescription Drug Plan. Enter your NJ PLUS Primary Care Physician's ID #

☐ I wish to be covered under NJ PLUS **only** and waive Prescription Drug Plan coverage.

2b. LEVEL OF NJ PLUS COVERAGE

☐ - Single ☐ - Family ☐ - Member & Spouse ☐ - Parent & Child(ren)

☐ - Member & Domestic Partner – (see instructions)

2c. LEVEL OF PRESCRIPTION DRUG COVERAGE

☐ - Single ☐ - Family ☐ - Member & Spouse ☐ - Parent & Child(ren)

☐ - Member & Domestic Partner – (see instructions)

3. WAIVER OF COVERAGE

☐ I elect to **waive** medical and prescription drug coverage for myself and for my dependents (see instructions).

4. DEPENDENT INFORMATION — *List all eligible dependents (see reverse).*

	Last Name	First Name	MI	Date of Birth Month Day Year	Gender (M/F)	Social Security Number	NJ PLUS Primary Care Physician's ID Number	Natural (C) Adopted (A) Step (S) Foster (F) Legal Ward (L) (See Instructions)
☐ **Spouse or** ☐ **Domestic Partner**								
Children								

5. TYPE OF ACTIVITY (complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

☐ Marriage - Date of Event (Mo/Day/Yr) _____
(Copy of Marriage Certificate required)

Former Name _____

☐ Domestic Partner - Date of Event (Mo/Day/Yr) _____
(Copy of Certificate of Domestic Partnership required)

☐ Birth of Child ☐ Adoption/Guardianship — Proof Required

Date of Event (Mo/Day/Yr) _____

5b. DELETION OF SPOUSE OR DOMESTIC PARTNER

☐ Separation ☐ Divorce ☐ Death

☐ Termination of Domestic Partnership

Date of Event (Mo/Day/Yr) _____

5c. DELETION OF CHILD

☐ Deletion of Child - Date of Event (Mo/Day/Yr) _____

Child's Name _____

Child's SSN _____

Give Reason _____

5d. OTHER CHANGES

☐ Change in last name only

(List Former Name) _____

☐ Change in Soc. Sec. # *(Attach copy of Social Security card)*

(List Former Soc. Sec. #) _____

☐ Change in Birth Date *(Attach copy of birth certificate)*

(List Name and Correct Date) _____

☐ Other - give reason (*i.e.*, address change, dependent returns from military service)

EMPLOYER CERTIFICATION

To Be Completed By Employer

Employer Name: _____

Location # 7 0

STATE ONLY: Payroll # Union Code (Rx) Only

MEMBER ACTION:

☐ **New Enrollment** — Must be completed

List Date of Pension Enrollment (Mo/Day/Yr)_____/_____/_____

OR

Pension Number _____ — _____

☐ **Transfer** Date _____/_____/_____

Name of Former Employer _____

☐ **Return from Leave of Absence** _____/_____/_____ (Mo/Day/Yr)

10/12 month employee

EMPLOYER CERTIFICATION — I certify that this part-time employee is eligible for enrollment under the provisions of Chapter 172, P.L. 2003, and that the information supplied on this form is true to the best of my knowledge.

_____
Signature of Certifying Officer

_____
Telephone # Date Mailed

6. Employee Certification —

I certify that all the information supplied on this form is true to the best of my knowledge. I authorize the Division of Pensions and Benefits to bill me for monthly premium payments as required by the provisions of Chapter 172, P.L. 2003. I understand that if I waive my right to coverage at this time, enrollment is not normally permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical service providers, either doctors or facilities in the NJ PLUS plan. If either my physician or medical center terminates participation in NJ PLUS, I must select another doctor or medical center participating in NJ PLUS to receive the "in-network" benefit. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

_____ _____
Employee's Signature Date Completed

COMPLETING THE PART-TIME EMPLOYEES GROUP NJ STATE HEALTH BENEFITS PROGRAM APPLICATION

QUICK REFERENCE

- This application is for use by part-time State employees and part-time faculy members at a state college or university, or county or community college who are eligible for State Health Benefits Program coverage under Chapter 172, P.L. 2003. For more information about this law and the eligibility requirements for Part-time employees, see Fact Sheet #66, *SHBP Coverage for State Part-time Employees.*
- **To change your primary care physician** (PCP) with NJ PLUS, contact Horizon Blue Cross Blue Shield directly at: 1-800-414-SHBP. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- To **enroll** for the first time complete all sections of the application with the exception of section 5.
- To **change coverage level** (adding/deleting dependents) complete sections: 1, 2a, 2b, and 2c (if applicable), 4, (be sure to list **all** eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To **add a dependent** complete sections: 1, 2a, and (as applicable) 2b and/or 2c, 4 (list all eligible dependents), 5a, and 6. If adding a new or previously uncovered spouse or eligible domentic partner, attach a photocopy of the marriage certificate or *Certificate of Domestic Partnership* to this application.
- To **terminate/decline coverage** complete sections: 1, and either 2a and 2b to terminate/decline prescription drug coverage only **or** 3 to waive **all** coverage, and 6. Note: If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 — EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 — MEDICAL COVERAGE

2a. **Check only one box** indicating if you want NJ PLUS **and** Prescription Drug Plan coverage or NJ PLUS coverage **only**. Be sure to provide your NJ PLUS Primary Care Physician's ID number. Refer to the NJ PLUS directory for this information or call NJ PLUS at 1-800-414-SHBP.

2b. Check the NJ PLUS coverage level desired.

2c. If you are selecting prescription drug coverage, check the Prescription Drug Plan coverage level desired.

Note: A Domestic Partner is defined for eligibility in the SHBP, by Chapter 246, P.L. 2003, as a person of the same sex to whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). If covering a Domestic Partner as a dependent, you must attach a photocopy of the *Certificate of Domestic Partnership* to this application.

SECTION 3 — WAIVER OF COVERAGE

If you do not want coverage under Chapter 172, check this box. Note: Once you decline or cancel coverage, enrollment is not normally permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 — DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b and 2c. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. An eligible spouse is an individual to whom you are legally married. An eligible domestic partner is an individual of the same-sex with whom you have entered into a domestic partnership (see note in instructions for Section 2, above). If you have listed a child that is a foster child, stepchild, legal ward, or has a different last name than the employee, proof of dependency is required (contact your payroll/personnel representative for an SHBP *Affidavit of Dependency* form). If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 4, and 6. For all dependents, include the NJ PLUS Primary Care Physician identification number. All dependents must have this information listed. Refer to the NJ PLUS directory for this information or call NJ PLUS at 1-800-414-SHBP.

Note: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 — TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and the event date.

5b. If you are deleting a dependent spouse or domestic partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box and give reason.

SECTION 6 — EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer. This application must be certified by the employer before submitting it to the SHBP. The Certifying Officer should:

1) Verify the employee's eligibility;

2) Verify that the application is legible and completed in its entirety;

3) Verify that the employee's selected plans and coverage levels are appropriate; and

4) Complete the Employer Certification section in its entirety.

For New Enrollments: The employer must provide the employee's Date of Pension Enrollment (if employee is a new enrollee, enter expected enrollment date based upon submission of the pension Enrollment Application) or the employee's Pension Membership Number.